DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/13/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G167	A. BUILDING _____ B. WING _____	08/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 10	1613 TAYLOR STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from August 27, 2009 to August 289, 2009. A random sampling of three clients was selected from a population of five individuals with varying degrees of disabilities This survey was conducted utilizing the fundamental process. The findings of this survey were based on observations at the group home and one day program, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	W 000	Received 10/23/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the three clients (Client #1) included in the sample. The finding includes: The facility failed to ensure that informed consent	W 124	The QMRP will be retrained on obtaining written informed consent for restrictive measures. The QMRP will also be retrained on how to submit proposed restrictive measures to the Human Rights Committee for review to ensure that each individual's rights are protected. 11/23/09	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Martha H. Thompson — Director of Disability Services — 10/23/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 was obtained from Client #1 and/or his legal guardian prior to implementation of his Behavior Support Plan (BSP). Observation of the morning medication administration on August 28, 2009, at 8:06 a.m. revealed Client #1 received medications including Seroquel 50 mg, Ativan 1 mg, and Risperidone 2 mg. Interview with the medication nurse on August 28, 2009 at xxxx time, revealed the aforementioned medications were used in conjunction with a BSP to manage behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the client's habilitation record on August 28, 2009, at 8:44 a.m. revealed that Client #1 BSP had been revised on July 6, 2009. Continued interview with the QMRP revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on the aforementioned date, at 8:56 a.m. through review of Client #1's psychological assessment dated September 8 2008. According to the assessment, Client #1 "currently functions with moderate cognitive and adaptive deficits. He is not able to make independent decisions concerning treatment plan, financial affairs, living arrangements or day placement. He lacks cognitive and academic skills necessary to understand the implications of such decisions, and therefore cannot give his informed consent in regards to these matters. He likewise cannot execute a durable power of attorney." According to the QMRP Client #1 had a family member (mother) that had agreed to assist him in decision making. Record verification on August	W 124		

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W 124	Continued From page 2 28, 2009 at 1:36 p.m., revealed a consent form for the prescribed medication was signed by the aforementioned family member dated August 20, 2009. Interview with the QMRP revealed that the revised BSP had not been reviewed/approved by the facility's Human Rights Committee (HRC). Additionally, the QMRP indicated that Client #1's revised BSP would be reviewed/approved at the facility's next HRC meeting which was scheduled for September 8, 2009. At the time of the survey, there was no evidence that the facility's specially constituted committee ensured that written informed consent had been obtained for the use of Client #1's revised BSP that incorporated restrictive techniques.	W 124		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a full and accurate accounting of client's financial records for two of five clients residing in the facility. [Clients #2, and #5] The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP), Financial Accounts Manager (FAM), the House Manager (HM) and record review on 8/28/2009 at approximately 7:00 p.m. revealed the facility could not account for the withdrawal of funds from the	W 140		

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W 140	Continued Fr om page 3 accounts of t vo of its residents. There was no evidence to s ubstantiate either the reason for the withdrawal or for what the funds were used. The evidences of the deficient practices are presented below: 1. Client #2 ' s 6/2009 Bank Statement reflect a withdrawal fo $350.00 was made on June 8, 2009. Furthe r record review revealed there were no receipts o statement(s) outlining what the funds were u ed for. Interview with the QMRP on August 27, 2 09 at approximately 7:15 p.m. revealed, the only documentation provided to her was the copi s of the bank statements. There was no additi onal documentation presented or made availab e for review. 2. Client #5 s 6/2009 Bank Statement reflect a withdrawal fo $250.00 was made on June 8, 2009. Furthe r record review revealed there were no receipts o statement(s) outlining what the funds were u ed for. Interview with the QMRP on August 27, 2 09 at approximately 7:20 p.m. revealed, the only documentation provided to her was the copi s of the bank statements. There was no additi onal documentation presented or made availab e for review. There was no evidence presented or on file at the time of surve to substantiate an effective system of record kee ping and oversight was in place with regards to the management of client ' s personal funds.	W 140	1. The QMRP will be retrained on the financial recordkeeping process for the facility, and will henceforward be able to produce evidence of how funds were expended upon request, which includes requesting copies of the receipts submitted along with the printed bank statements for authorized reviewers. 2. See response to #1 above.	11/23/09 11/23/09
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility m ust have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 4 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the investigation of a client's emergent care as required by this section for one (1) of three (3) randomly sampled clients. (Client #1) The findings include: 1. Staff interview and record review on August 28, 2009 at approximately 5:15 p.m. revealed an incident report dated March 19, 2009 was completed to address Client #1's "coughing, choking, and regurgitating". The incident report further accounts this client was taken to ER for treatment. Further interview with the facility's Qualified Mental Retardation Professional (QMRP) on August 28, 2009 at approximately 5:35 p.m. revealed there was no evidence that an investigation was initiated or completed to address this incident report. 2. Staff interview and record review on August 28, 2009 at approximately 5:45 p.m. revealed an incident report July 12, 2009 detailed Client #1 eloped from the residential facility and local law enforcement had to be involved in the missing person's search. Interview with Licensed Practical Nurse (LPN) on August 28, 2009at 6:32 p.m. revealed this client was missing for three days from Sunday (7/12/2009) to Tuesday afternoon (7/14/2009). The nurse further revealed they found out later that he was being held and under care at the DC Department of Mental Health's Comprehensive Psychiatric Emergency Program (CPEP) as a "John Doe". He was released on the evening of July 14, 2009 and transported back to the residential facility.	W 154	1. The QMRP will ensure that copies of completed incident investigations are maintained in the clients' records in the facility. All incidents are investigated by the Incident Management Coordinator and the QMRP, per facility policy. 2. See response to #1 above.	11/23/09

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W 154	Continued From page 5 Further interview revealed there was no evidence at the time of survey that an investigation was initiated or completed to address this incident.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for four of five clients residing in the facility. [Clients #1, #2, #3, and #5] The finding includes: Interview with the facility's QMRP on 1. The QMRP failed to ensure a full and accurate accounting of all financial records. [See W140] 2. The QMRP failed to ensure investigations were completed to address incidences of clients being provided emergent care. [See W154] 3. The QMRP failed to ensure Clients received a comprehensive psychiatric assessment prior to being prescribed psychotropic medications. [See W212] 4. The QMRP failed to ensure behavior support plans (BSP) had been reviewed and approved by	W 159	1. See response to W140. 2. See response to W154. 3. The Director of Disability Services will meet with the psychiatrists at Seton House, which is where clients receive their care. The DoDS will request that the Seton House psychiatrists provide comprehensive psychiatric assessments that can be updated as needed, prior to psychotropic medications being prescribed. 4. See response to W124.	11/23/09 11/23/09 11/23/09

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W 159	Continued Fr m page 6 the Human R ghts Committee (HRC) prior to implementati n. [See W262] 5. The QMF P failed to ensure that written informed con ent from either client or legal guardian was obtained prior to the implementati n of a Behavior Support Plan (BSP). [See V /263]	W 159		
W 214	483.440(c)(3) iii) INDIVIDUAL PROGRAM PLAN The comprehe nsive functional assessment must identify the cli ent's specific developmental and behavioral ma nagement needs. This STANDA RD is not met as evidenced by: Based on obs ervation, interview and record review, the fa ility failed to ensure that one of the three clients (lient #3) included in the sample that was pres ribed psychotropic medications, had a compre ensive psychiatric assessment. The finding in cludes: Observation o the administration of the morning medication on August 28, 2009, at approximately 7:48 a.m., rev aled Client #3 received Buspirone 15 mg by mou th Interview with the nursing staff on the aforem entioned date revealed that the medication wa s prescribed for anxiety and that he had a Behavio r Support Plan (BSP). Review of the lient's medical record on August 28, 2009, at a proximately 8:44 a.m., revealed a physician's or er (dated August 2009). According to the physicia 's order Buspirone 15 mg and Risperidone 3 mg was prescribed for Client #3 twice a day. T e physician's order also revealed that the client' diagnosis was "psychosis."	W 214	The Director of Disability Services will m et with the Psychiatry Department at Seton House which is the clinic where all clients served receive t eir psychiatric care. The DoDS will continue to follow up with the psychiatrists to ensure that a comprehensive evaluation is completed for each person served.	11/23/09

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W 214	Continued From page 7 Further review of the record revealed that the client's psychotropic medications was incorporated in a Behavior Support Plan dated February 14, 2009, to address behaviors associated with physical aggression, self-injurious behavior, and socially inappropriate self-stimulatory behaviors. Continued review of Client #3's record revealed a medical consult dated May 14, 2009. The consult indicated that the purpose of the visit was "psychiatric," however, the consult did not reflect any evidence of a comprehensive psychiatric evaluation, although the findings indicated "patient is stable with his explosive behavior" and the recommendations was to continue current medications. At the time of the survey, the facility failed to provide documented evidence that Client #3 had a comprehensive psychiatric evaluation that identified his current diagnosis.	W 214		
W 262	483.440(f)(3)( ) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a behavior support plan (BSP) had been reviewed and approved by their Human Rights Committee (HRC) for one of the three clients (Clients #1) included in the sample.	W 262	See response to W124.	11/23/09

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W 262	Continued From page 8 The finding includes: Observation of the morning medication administration on September 28, 2009, at 8:06 a.m. revealed Client #1 received medications including Seroquel 50 mg, Ativan 1 mg, and Risperidone 2 mg. Interview with the medication nurse on September 29, 2009, revealed the aforementioned medications were used in conjunction with a BSP to manage behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the client's habilitation record on August 28, 2009, at 8:44 a.m. revealed that Client #1's BSP had been revised on July 6, 2009. Interview with the QMRP acknowleged that the revised BSP had not been reviewed/approved by the facility's Human Rights Committee (HRC). Additionally, the QMRP indicated that Client #1's revised BSP would be reviewed and approved at the facility's next HRC meeting which was scheduled for September 8, 2009. At the time of the survey, there was no evidence that the facility's specially constituted committee ensured that Client #1's revised BSP that incorporated restrictive techniques had been reviewed and approved by it's HRC.	W 262		
W 263	483.440(f)(3)( ) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263	See response to W124.	11/23/09

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W 263	Continued From page 9 This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs was used only after written consents had been obtained, for one of the three clients (Client #1) included in the sample. The findings include: The facility failed to ensure that written informed consent was obtained from Client #1 and/or legal guardian prior to the implementation of his Behavior Support Plan (BSP). Interview with the Qualified Mental Retardation Professional (QMRP) on August 28, 2009, during the entrance conference revealed Client #1's medication was used in conjunction with a BSP to manage the client's behaviors. Review of the client's habilitation record on August 28, 2009, verified that Client #1 had a BSP dated July 6, 2009. According to the BSP, Client #1 received psychotropic medications for Intermittent Explosive Disorder; h/o alcohol abuse. Continued interview with the QMRP and record review revealed Client #1 was not capable of giving informed consent for the use of medications and habilitation services. According to the QMRP Client #1 had a family member (mother) that had agreed to assist him in decision making. At the time of the survey, the QMRP acknowledged there was no evidence that the facility's specially constituted committee ensured that written informed consent had been obtained	W 263		

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from 8/27/09 to 8/28/09. A random sampling of three residents was selected from a population of five individuals with varying degrees of disabilities. The findings of this survey were based on observations at the group home and one day program, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure the proper maintenance of the facility's environment for five of five residents [Residents #1, #2, #3, #4, and #5] residing in the facility as identified below: The findings include: During the environmental inspection on August 27, 2009 at approximately 5:30 p.m., the following deficient practices were identified: 1. Several areas along the walls in the bedrooms and hallway leading to the bedrooms were unpainted and plastered.	I 090	1. The Director of Operations will direct maintenance to plaster/paint the hallway walls.	11/23/09

Health Regulation Administration

Martha H. Thompson

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Director of Disability Services

(X6) DATE: 10/23/09

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I 090	Continued From page 1 2. An extremely loose toilet seat was found in the hall bath. 3. A broken towel rack was observed on the backside of the door leading into Resident #5's bedroom. 4. The closet door in Resident #5's bedroom was broken. 5. Peeling paint was observed around the light fixtures in the living room.	I 090	2. The Director of Operations will direct maintenance to repair the toilet. 3. The Director of Operations will direct maintenance to replace the broken towel rack. 4. The Director of Operations will direct maintenance to repair or replace the closet door. 5. The Director of Operations will direct maintenance to scrape and repaint the area where peeling paint was observed.	11/23/09 11/23/09 11/23/09 11/23/09
I 092	3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents and vermin. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a bug free environment for five of five residents residing in the facility. [Residents #1, #2, #3, #4, and #5] The finding includes: During the environmental inspection on August 27, 2009 at approximately 5:55 p.m., a spider's nest was observed on the light fixture for the front porch. Interview with the GHMRP's house manager and QMRP at the same time as the observation revealed the spider's nest should not be there and they would removed the nest immediately.	I 092	The Residential Director will inspect the house at least monthly to ensure there is no evidence of vermin or insect infestation. The spider's nest will be removed.	11/23/09
I 183	3508.4 ADMINISTRATIVE SUPPORT	I 183		

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	HFD03-0160	A. BUILDING _____ B. WING _____	08/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 10	1613 TAYLOR STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 183	Continued From page 2 Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning for four of five residents residing in the facility. [Residents #1, #2, #3, and #5] The finding includes: 1. The QMRP failed to ensure a full and accurate accounting of all financial records. [See Federal Deficiency Report Citation W140] 2. The QMRP failed to ensure investigations were completed to address incidences of residents being provided emergent care. [See Federal Deficiency Report Citation W154] 3. The QMRP failed to ensure Residents received a comprehensive psychiatric assessment prior to being prescribed psychotropic medications. [See Federal Deficiency Report Citation W214] 4. The QMRP failed to ensure behavior support plans (BSP) had been reviewed and approved by the Human Rights Committee (HRC) prior to implementation. [See Federal Deficiency Report Citation W262] 5. The QMRP failed to ensure that written informed consent from either resident or legal guardian was obtained prior to the	I 183	1. See response to federal deficiency W140. 2. See response to federal deficiency W154. 3. See response to federal deficiency W214. 4. See response to federal deficiency W262. 5. See response to federal deficiency W263.	11/23/09 11/23/09 11/23/09 11/23/09 11/23/09

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I 183	Continued From page 3 implementation of a Behavior Support Plan (BSP). [See Federal Deficiency Report Citation W263]	I 183		
I 375	3519.6 EMERGENCIES Each GHMRF shall document each emergency and enter the follow-up actions into the resident's permanent record, which shall be made available for review by authorized individuals. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the investigation of a resident's emergent care as required by this section for one (1) of three (3) randomly sampled residents. (Resident #1) The findings include: 1. Staff interview and record review on August 28, 2009 at approximately 5:15 p.m. revealed an incident report dated March 19, 2009 was completed to address Resident #1's "coughing, choking, and regurgitating". The incident report further accounts this resident was taken to ER for further treatment. Further interview with the facility's Qualified Mental Retardation Professional (QMRP) on August 28, 2009 at approximately 5 35 p.m. revealed there was no evidence that an investigation was initiated or completed to address this incident report. 2. Staff interview and record review on August 28, 2009 at approximately 5:45 p.m. revealed an incident report July 12, 2009 detailed Resident #1 eloped from the residential facility and local law enforcement was to be involved in the missing person's search. Interview with Licensed Practical Nurse (LPN) on August 28, 2009 at 6:32	I 375	1. See response to federal deficiency W154. 2. See response to federal deficiency W154.	11/23/09 11/23/09

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I 375	Continued From page 4 p.m. revealed this resident was missing for three days from Sunday (7/12/2009) to Tuesday afternoon (7/14/2009). The nurse further revealed they found out later that he was being held and under care at the DC Department of Mental Health's Comprehensive Psychiatric Emergency Program (CPEP) as a "John Doe". He was released on the evening of July 14, 2009 and transported back to the residential facility. Further interview revealed there was no evidence at the time of survey that an investigation was initiated or completed to address this incident.	I 375		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRF residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with mental retardation for one of the three residents (Resident #1) included in the sample. The finding includes: The facility failed to ensure that informed consent was obtained from Resident #1 and/or his legal guardian prior to implementation of his Behavior Support Plan (BSP). Observation of the morning medication	I 500	See response to federal deficiency W124.	11/23/09

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I 500	Continued From page 5 administration on September 28, 2009, at 8:06 a.m. revealed Resident #1 received medications including Seroquel 50 mg, Ativan 1 mg, and Risperidone 2 mg. Interview with the medication nurse on September 29, 2009, revealed the aforementioned medications were used in conjunction with a BSP to manage behaviors. Interview with the qualified mental retardation professional (QMRP) and review of the client's habilitation record on August 28, 2009, at 8:44 a.m. revealed that Resident #1 BSP had been revised on July 6,2009. Continued interview with the QMRP revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on on the aforementioned date, at 8:56 a.m. through review of Resident #1's psychological assessment dated September 8, 2008. According to the assessment, Resident #1 "currently functions with moderate cognitive and adaptive deficits. He is not able to make independent decisions concerning treatment plan, financial affairs, living arrangements or day placement. He lacks cognitive and academic skills necessary to understand the implications of such decisions, and therefore cannot give his informed consent in regards to these matters. He likewise cannot execute a durable power of attorney." According to the QMRP Resident #1 had a family member (mother) that had agreed to assist him in decision making. Record verification on August 28, 2009 at 1:36 PM, revealed a consent form for the prescribed medication was signed by the aforementioned family member dated August 20, 2009. Interview with the QMRP revealed that the revised BSP had not been reviewed/approved by the facility's Human Rights Committee (HRC).	I 500		

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I 500	Continued From page 6 Additionally, the QMRP indicated that Resident #1's revised BSP would be reviewed/approved at the facility's next HRC meeting which was scheduled for September 8, 2009. At the time of the survey, there was no evidence that the facility's specially constituted committee ensured that Resident #1's revised BSP that incorporated restrictive techniques, had been reviewed/approved by it's HRC. The QMRP acknowledged this finding.	I 500		